

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07485

CERTIFICATE OF DEATH

Reg. Dist. No. 07481

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and Oakland)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loch Lynn			
c. LENGTH OF STAY IN 1b 2 1/2 Yrs.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Wayman Middle Close Last Beckman				4. DATE OF DEATH Month July Day 5 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 4 Hours 19 Min. 57		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Garrett Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Beckman				14. MOTHER'S MAIDEN NAME Sarah Close			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT W. Elwood Beckman, R.D. 1, Oakland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility INTERVAL BETWEEN ONSET AND DEATH 2 Hours 420.0 Years Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1, 1957 to July 1, 1957 , that I last saw the deceased alive on July 1, 1957 , and that death occurred at 5:15 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5824 St. Charles, Md. DATE SIGNED 7-5-57 ACTUAL SIGNATURE James H. Feaster, M.D. PHYSICIAN'S NAME (Type) James H. Feaster, M.D. Oakland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/57		22c. NAME OF CEMETERY OR CREMATORY Beckman Cemetery		22d. LOCATION (City, town, or county) (State) Loch Lynn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Verbert C. Leighton ADDRESS Oakland, Md.				24a. RECEIVED BY REGISTRAR John A. Bowyer DATE 7/6/57			
24b. REGISTRAR'S SIGNATURE							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Residence		City		County	
Physician		Hospital		Burial Place	
Date of Burial		Time of Burial		Place of Burial	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Signature		Time of Signature		Place of Signature	

RECEIVED
JUL 11 1967
BUREAU V. S.

07486

CERTIFICATE OF DEATH

07483 6

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE # 2, BOX # 9		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARK - DILSWORTH				4. DATE OF DEATH Month Day Year JULY 16 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 3rd., 1877		9. AGE (In years last birthday) yrs. Months Days Hours Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-laborer General				10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME DILSWORTH, ISAAC John James				14. MOTHER'S MAIDEN NAME Victoria Moreland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Address ELMER DILSWORTH RT. #2, BOX #9, OAKLAND, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Benign prostatic hypertrophy DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 mos. 6 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/15/57 , 19 57 , to 7/16 , 19 57 , that I last saw the deceased alive on 7/16 , 19 57 , and that death occurred at 9:15 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph Alvarez M.D.				ADDRESS (Street, city or town, state) Oakland, Md.			
DATE SIGNED July 18, 1957							
PHYSICIAN'S NAME (Type) JOSEPH ALVAREZ M.D.				OAKLAND, MARYLAND JULY 18, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-18-1957		22c. NAME OF CEMETERY OR CREMATORY Underwood Cem.		22d. LOCATION (City, town, or county) (State) Near Oakland - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton				ADDRESS Oakland - Md.		24a. REC'D BY REGISTRAR DATE 7/19/57	
				24b. REGISTRAR'S SIGNATURE John A. Gowan			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINTAINING STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

BUREAU V. S.

JUL 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **166**

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural xi Oakland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Middle Last ARTIE EARL DODGE				4. DATE OF DEATH Month Day Year JULY 8 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1892	
9. AGE (In years last birthday) 65 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.	
13. FATHER'S NAME Daniel W. Dodge				14. MOTHER'S MAIDEN NAME Huldah Harned			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Artie Dodge		Address Oakland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUN SHOT WOUND OF HEAD 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACCIDENTAL DISCHARGE OF RIFLE DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 22 Rifle Accidentally Discharged			
20c. TIME OF INJURY Month, Day, Year 6:30 a.m. 7/8 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home near Oakland		20f. (City or town) (County) (State) Garrett Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. I. BADINGMARTNER				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. I. Badingmartner				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 7/11/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Red House Cemetery		22d. LOCATION (City, town, or county) (State) Red House Md	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton				ADDRESS Oakland, Md		24a. REC'D BY REGISTRAR John C. Howan	
				DATE 7/10/57		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. Fill out page 1 and 2 with the registrar or to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DO NOT WRITE IN THESE SPACES

BUREAU V. S.

JUL 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07485

07488

CERTIFICATE OF DEATH

Reg. Dist. No. 126

1. PLACE OF DEATH a. COUNTY GARRETT COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND, Carr. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN TB 12 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident			
d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 1 ONYX RD, MARYLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle I. Last FAZENBAKER				4. DATE OF DEATH Month JULY Day 21 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/85	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN FAZENBAKER				14. MOTHER'S MAIDEN NAME BITTINGER, SUZANNE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-2880		17. INFORMANT WIFE ANNIE, FAZENBAKER ACCIDENT, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peritonitis + Pelvic Abscess 442X DUE TO (b) Paracentesis for Ascites Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Ascites due to Cardiac Renal failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease				INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 weeks 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10, 1957 , to July 21, 1957 , that I last saw the deceased alive on July 20, 1957 , and that death occurred at 7:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert F. Leighton		M.D.		ADDRESS (Street, city or town, state) 77 Oak Street Oakland, Md		DATE SIGNED July 21 1957	
PHYSICIAN'S NAME (Type) HERBERT LEIGHTON		M.D.		OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/23/57		22c. NAME OF CEMETERY OR CREMATORY BE		22d. LOCATION (City, town, or county) (State) RURAL BIRMINGHAM, GARRETT CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Don J Newman, Grantville, Md				24a. REC'D BY REGISTRAR DATE 7/27/57		24b. REGISTRAR'S SIGNATURE Julius Newman Jr	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13 Days

Unemployed

BUREAU V. 2

JUL 31 1957

RECEIVED

Received 7/31/57
JUL 31 1957

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-45 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07486

07489 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>JENNINGS MD</u>		<u>LIFE</u>		TOWN <u>JENNINGS, MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
1				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>NORMAN</u> (Middle) <u>HOOVER</u> (Last)				(Month) <u>JULY</u> (Day) <u>29</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 YRS.
<u>M</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>Aug. 26, 1863</u>	<u>93</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>RETIRED</u>		<u>CARPENTER</u>		<u>GARRETT Co MD</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>CARLILE HOOVER</u>				<u>ROSANNA DURST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>(None)</u>		<u>NONE</u>		<u>HARRY HOOVER, GRANTSVILLE, MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Complete heart block</u>						<u>1 yr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						<u>20 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>None</u>		<u>433.0</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 1, 1956</u> , to <u>July 29, 1957</u> , that I last saw the deceased alive on <u>July 29, 1957</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>G. Paige Strong</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Penn.</u>		DATE SIGNED <u>7/30/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7/31/57</u>		<u>GRANTSVILLE</u>		<u>GRANTSVILLE, GARRETT Co MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>AUG 2 '57</u>		<u>Re. Smith</u>		<u>Donald Newman, Grantsville, Md</u>			

CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

RECEIVED
JUG 2 1957
BUREAU V. S.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0748766

07490

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aylett 83 X-5			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Week's Nursing Home				d. STREET ADDRESS 83 X-5			
3. NAME OF DECEASED (Type or print) First Walter Middle Weir Last Pollard				4. DATE OF DEATH Month July Day 9 Year 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1871	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired business				10b. KIND OF BUSINESS OR INDUSTRY Aylett, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Spottswood Pollard				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Walter W. Pollard, Jr., Hagerstown, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Consecutive heart failure DUE TO (c) Pyelonephritis + Cystitis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 29, 1957 , to July 7, 1957 , that I last saw the deceased alive on July 6, 1957 , and that death occurred at 10:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 77 Oak Street, Oakland, Md. DATE SIGNED 7/10/57							
ACTUAL SIGNATURE Herbert H. Leighton M.D.				DATE SIGNED 7/10/57			
PHYSICIAN'S NAME (Type) Herbert H. Leighton							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried 7/11/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Soudown Park		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton				24. REC'D BY REGISTRAR John C. Howan			

BUREAU V. S.

JUL 17 1957

RECEIVED

07491

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		MARYLAND		STATE MARYLAND		COUNTY GARRETT	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN RURAL SWANTON		LENGTH OF STAY (in this place) 75yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN RURAL SWANTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R#1-MT. ZION COMMUNITY				STREET ADDRESS (If rural give location) R#1- MT. ZION COMMUNITY			
3. NAME OF DECEASED (Type or Print) WILLIAM HENRY SHARPLESS				4. DATE OF DEATH (Month) (Day) (Year) JULY 5, 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED SINGLE	8. DATE OF BIRTH MAY 14, 1884	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) MT. ZION, GARRETT CO., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS REASON SHARPLESS				14. MOTHER'S MAIDEN NAME ELIZABETH FULMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) NO		16. SOCIAL SECURITY NO. 212-38-6581		17. INFORMANT & ADDRESS Bessie Sharpless, R#1, Swanton, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Thyroid Intoxication, Acute						Instantaneous	
ANTECEDENT CAUSE(S) DUE TO Arteriosclerotic Disease						2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Arteriosclerotic Heart Disease						7 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Thyroid Intoxication						8 weeks	
19a. DATE OF OPERATION 4/3/57		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-15-57 to 5-27-57, that I last saw the deceased alive on 5-19-57, and that death occurred at 5 A.M. from the causes and on the date stated above.							
SIGNATURE W. J. Smith M.D.				ADDRESS (Street, city, town, state) 58 W. St. Oran		DATE SIGNED 7-5-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/3/57		NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		LOCATION (City, town, or county) (State) R#1, Swanton, Md.	
24. REC'D BY REGISTRAR DATE 7/8/57		REGISTRAR'S SIGNATURE Chas. Barnd		25. FUNERAL DIRECTOR'S SIGNATURE O. J. Sharpless		ADDRESS Blaine, W. Va.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15 1-55 TOM

BUREAU V. S.

NO. 10 10

RECEIVED

074896

07492

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1 PLACE OF DEATH a. COUNTY GARRETT Co MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUPPETT NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) DANIEL First VLADICH Middle V Last		4. DATE OF DEATH Month JULY Day 1 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY-1883
9. AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER.		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? ??	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 232-09-2184	
17. INFORMANT CUPPETT NURSING HOME Address OAKLAND MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Asthma			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 1956 to July 1957 , that I last saw the deceased alive on July 1957 , and that death occurred at 8:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 252 Cedar St. Oakland MD. DATE SIGNED 7/2/57			
ACTUAL SIGNATURE [Signature] M.D.			
PHYSICIAN'S NAME (Type) ELI BAUMGARTNER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JULY-3-1957	22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY	22d. LOCATION (City, town, or county) (State) OAKLAND MD.
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS OAKLAND MD		24a. REC'D BY REGISTRAR 7/6/57	24b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 11 1957

RECEIVED

07493

CERTIFICATE OF DEATH

Reg. Dist. No. 163

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bloomington c. LENGTH OF STAY IN b 25 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 mi. W. Bloomington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bloomington d. STREET ADDRESS 1 mi. W. Bloomington e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Olavin John Warnick First Middle Last				4. DATE OF DEATH July 3 1957 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1884	
9. AGE (In years last birthday) 72 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) Bloomington, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Aaron M.T. Warnick		14. MOTHER'S MAIDEN NAME Katherine Barnard		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 217-01-9794		17. INFORMANT Mrs. Herbert Barnard, Swanton, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, infarction DUE TO Coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) disease (c) arteriosclerotic cardiovascular		INTERVAL BETWEEN ONSET AND DEATH 2 da	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4.2.1				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 21, 1957 to July 3, 1957 that I last saw the deceased alive on June 6, 1957 , and that death occurred at 1:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 209 Maryland Ave Westernport Maryland DATE SIGNED 7-5-57							
ACTUAL SIGNATURE Mildred E. Sheeley M.D.				PHYSICIAN'S NAME (Type) Westernport Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORY Turner Cem		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Roal				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR 7-6-57 DATE	
				24b. REGISTRAR'S SIGNATURE James Patterson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

07491
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07491

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 OAKLAND MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEEKS NURSING HOME				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ESTELLE MAE WINCHELL				4. DATE OF DEATH Month Day Year JULY - 22 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG-1-1963 9. AGE (In years last birthday) 94 1/3 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WOODSFIELD OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN DEVORE				14. MOTHER'S MAIDEN NAME MARY GRAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address WM. O. BITZER MT. LAKE PARK MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 1 week 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 15, 1957 , to July 22, 1957 , that I last saw the deceased alive on July 18, 1957 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton M.D.				ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. DATE SIGNED July 22, 1957			
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.				77 Oak Street, Oakland, Md. July 22, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY-23-1957		22c. NAME OF CEMETERY OR CREMATORY WOODSFIELD CEMETERY		22d. LOCATION (City, town, or county) (State) WOODSFIELD OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Baldwin ADDRESS OAKLAND MD				24a. REC'D BY REGISTRAR 1/22/57		24b. REGISTRAR'S SIGNATURE Julius C. Rowan	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include:]

NAME: ...
 SEX: ...
 AGE: ...
 DATE OF BIRTH: ...
 PLACE OF BIRTH: ...
 OCCUPATION: ...
 CAUSE OF DEATH: ...
 PLACE OF DEATH: ...
 DATE OF DEATH: ...
 SIGNATURE: ...
 REGISTERED: ...

BUREAU V. B.

JUL 24 1957

RECEIVED

07495

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY GARRETT	MARYLAND	STATE MARYLAND COUNTY GARRETT	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN GRANTSVILLE, MD	LENGTH OF STAY (in this place) 12 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GRANTSVILLE, MD	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
ROY HENRY ZEHNER		JULY 7 1957	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MAY 25, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INNKEEPER		10b. KIND OF BUSINESS OR INDUSTRY INN	9. AGE last birthday 56 yrs.
11. BIRTHPLACE (State or foreign country) GRANTSVILLE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN ZEHNER		14. MOTHER'S MAIDEN NAME SADIE BONIG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 169-01-6749	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Michael Zehner, Grantsville	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
4201 IMMEDIATE CAUSE (A) Coronary occlusion			1 hr.
ANTECEDENT CAUSE(S) DUE TO (B) atherosclerosis			3 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Curiosis			581.0
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 5, 1957 to July 7, 1957 , that I last saw the deceased alive on July 7, 1957 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
SIGNATURE Donald J. Newman		DATE SIGNED 7/9/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		24. REC'D BY REGISTRAR 7/10/57	
DATE JUL 15 '57		25. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

I hereby certify that on the 15th day of May 1937, at
 Grantville, Ohio, died
 John Zeher, male, white, born [illegible]
 married May 25, 1901, to
 Mary Zeher, female, white, born [illegible]
 wife of Henry Zeher, deceased, and
 daughter of [illegible] and [illegible]
 of [illegible] and [illegible]
 Cause of death [illegible]
 Signed and sealed this 15th day of May 1937.
 Registrar [illegible]
 County of [illegible] State of Ohio

BUREAU A. S.

JUL 15 1937

RECEIVED

1/10/37
 Grantville
 [illegible]
 [illegible]